TESTIMONY of JEAN MILLS ARANHA
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Before the APPROPRIATIONS COMMITTEE
In Opposition to HB 7040: An Act Implementing The Governor's Budget Recommendations For Human Services Programs and the Department of Aging Budget Cut to the Long Term Care Ombudsman Program

FEBRUARY 16, 2017

Good afternoon, my name is Jean Mills Aranha; I am an attorney at Connecticut Legal Services, Inc., a non-profit civil law firm dedicated to helping low-income people attain justice. I practice primarily elder and public benefits law, including cases for people who need long term care services and supports in both nursing facilities and home and community based settings. I am testifying today on behalf of our clients and the other very low-income, elderly and disabled residents of Connecticut.

OPPOSE the Reduction in income eligibility levels for the Medicare Savings Programs (Section 10)

The Governor's summary estimates that reduction in eligibility levels will affect approximately 39,000 elderly and disabled residents of Connecticut, terminating this benefit for them. Most of these people are on the Qualified Medicare Beneficiary program, or QMB (approximately 85% of MSP recipients are on QMB[1]). The Governor proposes to reduce the income limit for QMB to 135% of Federal Poverty Level, or $1,324.12 per month for one individual. I'd like to explain specifically what the loss of that program would mean for one of my low income clients.

The QMB program pays a person's Medicare premiums (Part B and D, and occasionally Part A), deductibles and co-pays. A QMB beneficiary also automatically qualifies for a Low Income Subsidy or "Extra Help" with prescription drug coverage from the federal government, which pays the Part D premium and reduces co-pays to between $3.30 and $8.75, and provides coverage in the infamous "donut hole".

Losing QMB status would mean that an elderly or disabled person with monthly income of $1,325 or greater will suddenly have to pay the following extra expenses each month:

- Part B Premium of $109 (or $134 if a new enrollee)
- Part D Drug Coverage Premium of about $34 (average monthly premium)
- 20% of most medical provider cost.
- Drug co-pays of 25% of the cost of each prescription (and more during the "donut hole" gap in coverage).

[1] Department of Social Services Avery Monthly Assistance Units and Recipients by Town, State Fiscal Year July 2015-June 2016) (71,848 total QMB, 12,060 total SLMB/ALMB)

- A deductible each year of $183 for doctor's visits (or other Part B services).
- A deductible of $1316 for a hospital visit (for each "spell of illness" which can occur more than once a year).
- A deductible of up to $400 for drug coverage.

The first month a woman loses her QMB coverage, assuming she has two prescription medications, on a generic costing $10 and one a name brand drug costing $100, **she would have to pay $243 out of pocket for her health coverage and her medication**s. ($109 Part B premium, $34 Part D premium, and $110 for the medications, because she has a $400 deductible to meet.) That means that she must now devote 18% of her income to her medical coverage – in a healthy month.

To make matters worse, the private Part D plans are allowed to impose a waiting period for people with pre-existing conditions, so this woman might have to go 2-6 months paying the full price for all her medications.

If she becomes ill, and has **to see her doctor, the first visits of the year will be paid completely by her, up to her $183 Part B deductible.** And **should she have to go into the hospital, she will have to pay the first $1,316 of her hospital bill to satisfy her deductible**. So, with just one short hospital stay would incur medical costs in excess of her total income for the month. (**If she has a long stay, she will have an additional copay of $322 per day each day after the 60th day.**)

Finally, **if this woman needs to go to a skilled nursing facility for rehabilitation** after a hospital stay, after her 20th day there, she will have a co-pay of $164.50 for each additional day. So **a 30 day stay would cost her $1,640**. And if she has a second stay within the same year, she does not get any additional fully covered days, **so another two weeks at the rehab facility would cost her $2,303**. Given her income, she's likely to try to go home early, or not go at all, foregoing vital rehabilitation.

Regardless, between the hospital and the nursing facility, she is likely to be in debt that she will struggle to ever pay off.

Commercial insurance companies offer supplemental or "Medigap" policies to cover co-pays and deductibles. But the cost for a policy that covers these items starts at about $200 per month, and many are more expensive.

Many of the people who will be terminated from QMB will no longer be able to make ends meet without the program. They simply do not have these amounts of discretionary income available to pay for their medical coverage and care. They are already living from month to month and choosing which bills to pay and not pay. As a result, they will have to make choices about whether to maintain medical coverage or stop paying for other necessities – such as rent, food, transportation and utilities.

Remember too that these people are not eligible for Medicaid, because the income limits for HUSKY C (the Medicaid program for the elderly and disabled) are at about 100% of the

Federal Poverty Guidelines. So those who chose not to pay for Medicare will be entirely without medical insurance.

This proposed cut threatens the health and economic stability of a large number of elderly and disabled residents. We strongly urge you to keep this program at current levels.

OPPOSE Ending the Vital Medicare Part D Drug Co-Pay Protection for our Poorest Elders and Disabled (Section 12).

This cut affects people who are eligible for both Medicare and Medicaid, known as the "dual eligibles". Being eligible for two health care programs sounds good; but in fact, only the poorest of our elder and disabled residents qualify. To be dually eligible, you must be on HUSKY C, which has an income cap of $860 or $970 (depending on what part of the state you live in) for an individual, and $1,101 or $1,210 for a couple; this is almost exactly the federal poverty level. Many of these people have poor health; it has been estimated that 14% of them take seven or more medications per month.

For many years, Connecticut provided that drug co-pays for these residents was capped at $15 per month, in recognition of their low income. In 2014, this protection was removed by the legislature, causing significant hardship to people who already lead hard lives. Elderly and disabled people without means have been forced to go without needed medications when they cannot afford their co-pays, or to choose between food, utilities and their medications. Last session, in recognition of this hardship for modest projected savings ($90,000), the cap was reinstated, at $17.

In addition to causing suffering, denying chronically ill and elderly people medications that control their conditions will inevitably end in emergency room visits and hospital stays for some. The costs for just a few people getting very ill could easily exceed the projected savings of this cut. It is "penny wise and pound foolish," in addition to being a burden on a population already struggling to live on a meager income.

OPPOSE the Elimination of a Regional Long Term Care Ombudsman from the Department of Aging Budget.

This is another relatively small projected savings ($90,466) that will have a large negative impact. There are approximately 36,000 residents of nursing facilities, residential care homes and assisted living facilities served by Connecticut's regional ombudsmen. My clients live in these settings, and many of them are isolated and without family or friends to help them when they have a problem or feel their rights or privacy are not being respected. They feel too vulnerable to complain to the staff, on whom they are dependent for their daily personal care. I often work with the Long Term Care Ombudsmen, and have found them to be unfailingly professional and exceptionally skilled in fielding complaints and helping to resolve problems experienced by these residents. Often, they are called to help with problems of inadequate care and treatment by staff, as well as discharge and eviction.

In addition to individual casework, the Ombudsmen leverage their impact by recruiting and training Volunteer Resident Advocates who visit nursing homes in their communities to assist residents in resolving problems associated with their quality of life and quality of care. The Ombudsman Program also works collaboratively with organizations within the long term care network to raise awareness of the issues faced by residents in long term care settings.

We should not dilute the good work of the LTCOP by eliminating a Regional Ombudsman, thereby allowing fewer residents to be served.

OPPOSE: Extension of Freeze on Intake for Category One and Extreme Restriction on Intake for Category Two of the Connecticut Home Care Program for Elders (CHCPE) (Section 25)

In 2015, the legislature froze intake for Category One of CHCPE, which provided services to elderly people who were considered "at risk" of needing nursing home placement. The goal of Category One was to help people remain in their homes at lower cost to the state and avoid or delay the need for nursing home level of care. This freeze was enacted for two years, to end in 2017. Now the freeze is extended, apparently indefinitely. We urge the Committee to recommend reopening Category One of CHCPE to help people maintain their independence at home and avoid the need for (and higher cost of) nursing home placement.

In addition, Section 25 proposes to effectively close Category Two of the CHCPE, by limiting its enrollment to the number of people receiving Category Two services on July 30, 2017. Category Two provides services to elders who require nursing home level of care, but do not qualify financially for Category Three CHCPE, the Medicaid waiver.

The result of this restriction on the Category 2 program will be that some (and probably many) of these individuals will have to go into nursing homes. This makes no sense from a fiscal point of view, as they will soon deplete their modest assets and qualify for Medicaid in the facility, often at a higher cost than the home care program.

More importantly, virtually no one wants to leave his or her home to live in a nursing facility. When a person cannot get Category One or Category Two CHCPE services, the risk of falling, being injured or becoming ill is increased. These events can and do lead to emergency room visits, hospitalizations and nursing home stays, some of them permanent. These consequences of not having adequate levels of home care are costly in both economic and human terms.

The psychological and physical effects on frail elders moving from one residence to another are well documented. Such transfer or relocation trauma can cause frail, elderly people to deteriorate mentally and physically when they are moved involuntarily from their homes to nursing facilities.

Furthermore, the cost of hospital and/or nursing home care is generally greater than the cost of home care services. Then, the state may incur the additional cost of moving the person back to the community. It is very difficult to maintain an apartment in the community while residing in a nursing home because Medicaid law only allows a limited amount of the resident's income to be used for rent in the community. If the person loses his apartment while in the nursing home, it takes longer to transition back to the community because of the scarcity of subsidized apartments for the elderly.

Reopening Category One of CHCPE and retaining Category Two would continue the great strides Connecticut has made to rebalance its long term services and supports in favor of maintaining people in the community, as well as reducing economic costs and human suffering.

I had a very difficult time preparing this testimony. Deciding which cuts to discuss in depth among so many that will be damaging was painful and discouraging. Although the budget challenges are tough, we can do better than to solve our problems by making the lives of low income people harder.

I have chosen to address the cuts that I believe will have the most impact on my clients and others similarly situated, who are some of the most vulnerable of Connecticut residents. I endorse the testimony of my legal services colleagues who are addressing other issues, particularly regarding HUSKY A parents, adult dental services and DSS staffing. You have a terrible responsibility in your decisions on this bill and budget, and I appreciate the time, energy and compassion you must bring to those decisions.

Respectfully submitted,

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